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FISCAL IMPACT STATEMENT

LS 7108
BILL NUMBER: HB 1325

NOTE PREPARED: Jan 11, 2010
BILL AMENDED:

SUBJECT: Long-Term Care Services.

FIRST AUTHOR: Rep. Crouch
FIRST SPONSOR:

BILL STATUS: As Introduced

FUNDS AFFECTED: X **GENERAL**
X **DEDICATED**
X **FEDERAL**

IMPACT: State

Summary of Legislation: This bill provides the Area Agencies on Aging (AAAs) with flexibility in the management of certain program funding, and prohibits the Division of Aging (DOA) from imposing restrictions that are not in the DOA's contract with a AAA.

The bill allows spouses and parents of individuals who are at risk of being institutionalized to provide attendant care services, and limits the amount of services that can be reimbursed.

The bill also requires the dissemination of specified information as part of: (1) the screening and counseling program for individuals seeking long-term care services; (2) a nursing facility's notification to applicants; (3) the nursing facility preadmission screening program; and (4) the hospital discharge process.

The bill prohibits a patient from being discharged from a hospital to a nursing facility in which certain representatives of the hospital have a financial interest unless the patient consents to the discharge and authorizes the DOA to charge hospitals for specified costs for certain inappropriate placements.

The bill also allows a AAA to make presumptive eligibility determinations for the Aged and Disabled (A&D) Medicaid waiver under specified circumstances.

Effective Date: July 1, 2010.

Explanation of State Expenditures: *Presumptive Eligibility (PE):* The bill would establish a state-funded presumptive eligibility program for Medicaid Aged & Disabled waiver applicants. The bill would allow the Area Agencies on Aging to make a determination that an applicant, who is at risk of being institutionalized

if immediate long-term care services are not received, is presumptively eligible for a defined number of Medicaid A&D waiver services if a Medicaid application has been completed and the AAA has determined the applicant is deficient in at least three activities of daily living. The AAA's determination of presumptive eligibility would allow for the immediate provision of the allowable services needed by the applicant. The bill provides that the AAAs would have the flexibility to determine how services would be funded until such time as the applicant is determined to be eligible for the Medicaid A&D waiver.

The cost of this provision is associated with the number of persons that might be determined to be presumptively eligible, the expense of services provided to persons subsequently found to be ineligible for Medicaid, and with the associated state administrative expense. Presumably, any services provided that are not eligible for Medicaid reimbursement would be funded by the CHOICE state appropriation. Data are not available to determine how many PE determinations might be made and how many may result in additional state expenditures. Available CHOICE funds are limited and other program dollars that might be substituted are currently being used to provide services. According to the Family and Social Services Administration (FSSA), the agency does not have resources to provide for necessary administrative expenses to implement the PE provision at this time.

Flexibility of Service Funding by AAAs: The bill would require FSSA to refrain from imposing any restrictions on a AAA other than those required under the terms of the contract with the AAA. This would allow the 16 AAAs to manage funds among 14 separate programs with increased flexibility. This provision would presumably allow the AAAs to use CHOICE or other appropriate funds to provide funding to pay for services provided under PE determinations that are later determined to be ineligible for Medicaid A&D waiver services.

FSSA is the single state agency that is accountable to the federal government for the expenditure of federal dollars under several of the programs. This provision would require the agency to turn over responsibility for the expenditure of funds to 16 AAAs after the contracts with FSSA are executed. The cost of this provision would depend on administrative actions; FSSA could write the terms of the contracts to provide for more administrative control. This could increase administrative expense as contract amendments would be a method for maintaining accountability.

A&D Waiver Considerations: The PE provision would require that waiver slots be available in sufficient quantity to allow the 16 AAAs to make independent determinations of presumptive eligibility. FSSA reported that 463 Medicaid applicants were added to the A&D waiver waiting list in the month since the available 10,409 waiver slots were filled December 3, 2009. FSSA also reported that an additional 1,000 waiver slots are budgeted to open at the beginning of FY 2011and FY 2012. In order to implement the PE provisions in the bill, FSSA would need to amend the waiver to open A&D waiver slots sooner than originally requested. FSSA would also need to amend the waiver to request additional slots.

The presumptive eligibility provision would have to be closely tracked by FSSA to ensure that PE and services are not provided to more individuals than there are available waiver slots. This is especially important since waiver slots must be demonstrated to be fiscally neutral to the federal government, and Medicaid waiver clients would also be eligible for full State Plan services during the look-back period. This expense may actually cost more than the home and community-based services provided for the PE period. Medicaid expenditure reports show that in FY 2009, the state spent $84.4 M on waiver expenditures and $143.2 M on State Plan services for waiver clients.

The Indiana Medicaid appropriation provides a single open-ended dollar amount for all services provided

under the program. While the Office of Medicaid Policy and Planning (OMPP) may have targeted amounts for expenditure classifications such as nursing facilities, hospitals, and waiver services, OMPP has the flexibility within the single appropriation to reallocate funds between expenditure classifications as necessary.

Savings in one area of the program can be applied to expenditures in another area internally within the budgeted appropriation. Any savings under the provisions of this bill would be related to the number of Medicaid nursing home admissions that would be prevented by the provision of home and community-based care services. Any savings that may result from fewer nursing facility admissions than originally projected may or may not be available to expand services in the waivers. If the number of eligible participants entitled to Medicaid Plan services expands above the projected levels in other eligibility categories, funding freed up by savings may be needed to provide entitlement services.

Rule Promulgation: The bill would require FSSA to promulgate two sets of rules: the first, to determine a list of home and community-based services that could be provided to Medicaid applicants determined to be presumptively eligible for A&D waiver services; and the second, to provide for the provision of compensation for attendant care services provided by the parent of a minor child or a spouse. Rule promulgation is considered to be a routine administrative function that should be able to be provided within the level of resources available to the agency

PE Administrative Expense: FSSA currently has no administrative procedure in place to accommodate a state-funded PE process. The information technology system that tracks AAA waiver-related activities is antiquated and is reported to need replacement. FSSA reports that the system could not accommodate tracking activities necessary to implement PE. Information technology system requirements and personnel needs that may be associated with the PE program are not known at this time. [FSSA is currently working on an estimate. This information will be updated when the estimate is received.] The AAAs are not mandated to make PE determinations by the bill. The level of resources required for the AAAs to perform the PE is not known at this time. If additional resources would be needed, FSSA does not have resources to provide additional funding for the AAA contracts without cutting some other existing service.

Compensation for Personal Attendant Services: The bill allows for parents of dependent children and spouses to receive compensation for personal attendant services provided for no more than 40 hours a week under rules to be promulgated by FSSA. This provision should be budget neutral since the individuals eligible for the services could have them provided by any provider. Attendant services included in the individual's care plan are limited to the hours of care needed. This provision would allow a close family member to receive compensation under circumstances defined by FSSA.

Distribution of Required Information: The bill requires AAAs, nursing facilities, and hospitals to give AAA contact information and information on local long-term care services options available to individuals. The bill requires OMPP to prepare the list of available local services. It is unclear if this would be a service covered under the AAA contracts or if OMPP would need to provide compensation to have the specific lists developed. AAAs are required to provide this information within seven days of a person's admission to a nursing facility. It is not known at this time if the 16 AAAs have sufficient staffing resources to accomplish this requirement without additional funding.

Hospital Requirements: The bill specifies that hospitals must identify long-term care facilities on the list of local service options in which the hospital, members of its medical staff, governing board, or executive staff has any financial interest. The bill provides that a patient may not be discharged to such a facility unless

consent has been given. The bill allows FSSA to charge a hospital with the costs that are incurred by the state and the patient to correct a placement made under this situation. The cost of this provision would depend on individual circumstances. FSSA may need to promulgate rules to define a recovery process.

Background Information-

Presumptive Eligibility Background Information: Federal Medicaid matching funds are available for services provided during a period of presumptive eligibility for home and community-based services that are State Plan services - but not for waiver services. For example, Indiana has PE for State Plan services for pregnant women. If a woman receives pregnancy-related services during a PE period and is later determined to be ineligible for Medicaid, the federal matching rate is still available to reimburse for those services. Because the home and community-based services provided under the A&D waiver are not State Plan services, any services provided during a PE period for a person who is found to be ineligible for Medicaid would not be eligible for reimbursement under the Medicaid program - those expenses would need to be reimbursed using all state dollars or recovered from the applicant.

Once a determination of eligibility has been made, Medicaid regulations provide for a three-month look-back period. Any waiver services and State Medicaid Plan services provided during the look-back period are reimburseable under the Medicaid program and eligible for federal matching funds. Nursing facilities currently may decide to admit a patient under the assumption that they will be determined to be Medicaid-eligible; however, the nursing facility takes the risk that later they might have to try to collect reimbursement from the patient if the patient is subsequently determined to be ineligible for Medicaid. Consequently, the cost associated with this provision is related to the expense of services provided to persons subsequently found to be ineligible for Medicaid, and with the associated administrative expense.

[FSSA is currently inquiring of CMS if a waiver for PE for the A&D waiver is a possible option for the state. This information will be updated when FSSA receives an answer.]

CHOICE Funding Background Information: The PE provision assumes that CHOICE funding or some other source of funding is available to provide services to persons subsequently determined to be ineligible for Medicaid. The annual appropriation for CHOICE is $48.8 M for each year of the budget biennium. Of the total appropriation, up to $12.9 M may be transferred each year to Medicaid to provide state matching funds for the A&D waiver, leaving a minimum of $35.9 M available for CHOICE services. The account disbursed 32.0 M for services in FY 2009 and appears to be spending at a slightly faster rate than in previous years. The dedicated CHOICE appropriation is nonreverting; $4.77 M was rolled over to the fund at the end of FY 2009.

FSSA reports that the CHOICE program had 2,161 individuals waiting for services as of January 4, 2010. Depending on the number and accuracy of the presumptive eligibility determinations made by the 16 AAAs, the CHOICE appropriation may not have sufficient funds to provide for temporary limited services to individuals found to be ineligible for A& D waiver services. With PE, the program could not consider extending services to individuals on the waiting list.

Explanation of State Revenues:

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: FSSA, OMPP and the DOA.

Local Agencies Affected:

Information Sources: FSSA.

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